DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11037A (Rev. 06/03)

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / SUBSTANCE ABUSE DAY TREATMENT ATTACHMENT (PA/SADTA) COMPLETION INSTRUCTIONS

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed. Refer to the AODA Day Treatment Handbook for service restrictions and additional documentation requirements. Provide enough information for Wisconsin Medicaid medical consultants to make a reasonable judgment about the case.

Attach the completed Prior Authorization/Substance Abuse Day Treatment Attachment (PA/SADTA) to the Prior Authorization Request Form (PA/RF) and physician prescription (if necessary) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

The provision of services that are greater than or significantly different from those authorized may result in nonpayment of the billing claim(s).

SECTION I — RECIPIENT INFORMATION

Element 1 — Name — Recipient (Last, First, Middle Initial)
Enter the recipient's name exactly as it appears on the recipient's Medicaid identification card.

Element 2 — Age — Recipient
Enter the age of the recipient in numerical form (e.g., 16, 21, 60).

Element 3 — Recipient Medicaid Identification Number
Enter the recipient's 10-digit Medicaid identification number exactly as it appears on the recipient's Medicaid identification card.

SECTION II — PROVIDER INFORMATION

Element 4 — Name and Credentials — Requesting / Performing Provider
Enter the name and credentials of the therapist who will be providing treatment/service.

Element 5 — Telephone Number — Requesting / Performing Provider
Enter the performing provider's telephone number, including area code.

Element 6 — Name — Referring / Prescribing Provider
Enter the name of the provider referring/prescribing treatment.

Element 7 — Referring / Prescribing Provider's Medicaid Provider Number
Enter the referring/prescribing provider's eight-digit provider number.

The remaining portions of this attachment are to be used to document the justification for the service requested. **Substance abuse day treatment is not a covered service for recipients who are residents of a nursing home or who are hospital inpatients.**

SECTION III — DOCUMENTATION

Element 8
Describe the length and intensity of treatment requested. Include the anticipated beginning treatment date and estimated substance abuse day treatment discharge date, and attach a copy of treatment design.

Element 9
List the dates of diagnostic evaluations or medical examinations and **specific** diagnostic procedures that were employed.

Element 10
List the codes and descriptions from the most recent *Diagnostic and Statistical Manual of Mental Disorders* (DSM) for the recipient's current primary and secondary diagnosis. Allowable DSM diagnoses are 303.90 (alcohol dependence), 304.00-304.90 (drug dependence), 305.00 (alcohol abuse), or 305.20-305.90 (other drug abuse) (excluding caffeine intoxication).

Element 11
Describe the recipient's current clinical problems and relevant clinical history, including substance abuse history. (Give details of dates of abuse, substance(s) abused, amounts used, date of last use, etc.)

Element 12
Indicate if the recipient has received any substance abuse treatment in the past twelve months.

Element 13
If the recipient received any inpatient substance abuse care, intensive outpatient substance abuse services, or substance abuse day treatment in the past twelve months, give rationale for appropriateness and medical necessity of the current request. Discuss projected outcome of additional treatment requested.

Element 14
Describe the recipient's severity of illness using the indicators in a-f. Refer to the substance abuse day treatment criteria in the AODA Day Treatment Handbook.

Element 15
Discuss the recipient's treatment plan and attach a copy of the plan.

Element 16 — Signature — Recipient or Representative
Signature of the recipient or representative indicates the signer has read the attached request for PA of substance abuse and agrees that it will be sent to Wisconsin Medicaid for review.

Element 17 — Date Signed
Enter the month, day, and year the PA/SADTA was signed by the recipient or the recipient's representative (in MM/DD/YY format).

Element 18 — Relationship (if representative)
Include relationship to recipient (if a representative signs).

Element 19 — Signature — Performing Provider
Enter the signature of the performing provider.

Element 20 — Date Signed
Enter the month, day, and year the PA/SADTA was signed by the performing provider (in MM/DD/YY format).

Element 21 — Discipline of Performing Provider
Enter the discipline of the performing provider.

Element 22 — Signature — Supervising Physician or Psychologist
Enter the signature of the supervising physician or psychologist.

Element 23 — Date Signed
Enter the month, day, and year the PA/SADTA was signed by the supervising physician or psychologist (in MM/DD/YY format).

Element 24 — Supervising Physician or Psychologist's Medicaid Provider Number
Enter the supervising physician or psychologist's Medicaid provider number.